

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12447

12452

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 rural Eden</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1 Route 1, Box 65B</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Moses</u> Middle <u>Allen</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9 1909</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Allen</u>				14. MOTHER'S MAIDEN NAME <u>LUEVENIA DONALDSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>265-168385</u>		17. INFORMANT <u>Hospital Records, Peninsula Gen. Hosp</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kidney</u> DUE TO <u>arteriosclerotic nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Hypertensive Cardio Vascular Disease</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Contusion and laceration of right leg</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>Oct 25 1957</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Kendrick Mc Cullough</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Kendrick Mc Cullough</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acre Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md</u>				24. REC'D BY REGISTRAR <u> </u>			
				25. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

BUREAU V. 2

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be emulated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12453

CERTIFICATE OF DEATH

12448

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 1939-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>135 South Fourth St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ames</u> Last <u>Ames</u>				4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 1, 1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>CRISFIELD, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE W. AMES</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BROUGHTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>175-05-0990</u>		17. INFORMANT Address <u>Miss ROSIE AMES - 214 N. 4TH ST. - CRISFIELD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Misleading Thrombosis</u> <u>450.0</u> DUE TO (b) <u>Emphysema arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arrhythmia Fibrillation + Tuberculosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-18</u> 19 <u>57</u> , to <u>11-23</u> 19 <u>57</u> that I last saw the deceased alive on <u>11-23</u> 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. D. Briele</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>11-27-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAWSONIA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS - CRISFIELD, MD.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>12-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harry W. Holloway</u>	

CERTIFICATE OF DEATH

ALL TANSO STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. S.

DEC 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 515 Wailes St				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
f. STREET ADDRESS 515 Wailes St				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle ALEXANDER Last AYRES				4. DATE OF DEATH Month NOV. Day 10 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1886	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wesley B. Ayres				14. MOTHER'S MAIDEN NAME Amanda Morse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 139-03-3926		17. INFORMANT Mrs. Kathryn W. Ayres (Wife) Address 515 Wailes St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Central Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-vascular mural lesion DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1956 to 11-10 1957 , that I last saw the deceased alive on 11-10 1957 , and that death occurred at 11:15A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley				DATE SIGNED 11-11-57			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				Main St. Salisbury, Maryland Nov. 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Fernwood Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR NOV 19 1957		24b. REGISTRAR'S SIGNATURE Mary M. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 5

NOV 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. If death occurs at home, the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG223 12-20-57 et

Reg. Dist. No.

12450

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 411 W. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Linda Pearl Baker		4. DATE OF DEATH 11 5 1957	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 26, 1920
9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Barma	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William		14. MOTHER'S MAIDEN NAME Bessie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14877	
17. INFORMANT Sulton Williams		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive C. V. Disease (a) stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 11-8-57	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial 11-10-57 Green Acres		22b. LOCATION (City, town, or county) (State) Salisbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. W. M. West		24a. REC'D BY REGISTRAR NOV 12 1957	
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

RECEIVED
NOV 12 1957
BUREAU V. A.

CERTIFICATE OF DEATH

Reg. Dist. No. 332

12456

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 14 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		/d. STREET ADDRESS 503 S. Pinehurst	
3. NAME OF DECEASED (Type or print) ELBERT MILTON BARBON		4. DATE OF DEATH Month 11 Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1908
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 11 Days 23 Hours 19 Min.	11. IF UNDER 24 HRS. Months 11 Days 23 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman or Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Barbon		14. MOTHER'S MAIDEN NAME Nettie Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-9659	
17. INFORMANT Mrs. Elizabeth G. Barbon, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease 480.1 DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Py. DUE TO (c) Py.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Py.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. p. m. Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/22, 1957 to 11/23, 1957 that I last saw the deceased alive on 11/22/57 , and that death occurred at 4:15 AM , from the cause and on the date stated above.			
ACTUAL SIGNATURE David J. Gilmore		DATE SIGNED Nov. 25, 1957	
PHYSICIAN'S NAME (Type) DAVID J. GILMORE		SALISBURY, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/57	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Pk.		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co.		24a. REC'D BY REGISTRAR 11-25-57	
ADDRESS Salisbury, Maryland		24b. REGISTRAR'S SIGNATURE Marion W. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Handwritten text, likely a signature or name, appearing upside down.

BUREAU A. S.

NOV 27 1957

RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

EDMUND V. S.

RECEIVED

12458

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nantuxie</u>			
c. LENGTH OF STAY IN 1b <u>12 Days</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Southern BARCLAY</u>				4. DATE OF DEATH Month Day Year <u>November 19 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/12/91</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>4 7</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Factory</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas A. Barclay</u>				14. MOTHER'S MAIDEN NAME <u>Octavia Conway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, for unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-18-4640A</u>			
17. INFORMANT Address <u>Violon Barclay, 9001 Taylor Road</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis with Cholecystitis. Biliary Tract Disease. Hypertrophy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL _____ M.D. _____							
PHYSICIAN'S NAME (Type) <u>David J. Gelman M.D. Salisbury Md.</u> <u>Nov. 20, 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nantuxie Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nantuxie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. D. Fessell, Brooke, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers.

1. Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1957

RECEIVED

12459 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE EDNA BELLMAN</u>				4. DATE OF DEATH Month Day Year <u>November 19 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-1897</u>	
9. AGE (In years last birthday) yrs. <u>70</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JAMES BROWN</u>		14. MOTHER'S MAIDEN NAME <u>EDNA OLIPHANT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>CHARLES BELLMAN-DELMAR, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3.4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11-19</u> , 19 <u>57</u> , to <u>11-22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>57</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William R. Ellis, M.D.</u>							
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR-DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall Co - Delmar, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>12-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO REGISTRAR: This certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1

1910

12460

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GEN. Hosp.</u>		d. STREET ADDRESS <u>Rt. 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Edward</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19 1865</u> AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>William F. Brown</u>		14. MOTHER'S MAIDEN NAME <u>LOVEY J. HEARN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>I. Frank Brown - Salisbury, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-23</u> 19 <u>57</u> to <u>Oct 11-3</u> 19 <u>57</u> that I last saw the deceased alive on <u>11-3</u> 19 <u>57</u> , and that death occurred at <u>6:07 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A.C. Mitchell</u> M.D.			
PHYSICIAN'S NAME (Type) <u>A.C. Mitchell M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL Specify <u>BURIAL</u>	22b. DATE THEREOF <u>11/5/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bill Johnson</u>		ADDRESS <u>Salisbury, Md</u>	24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>William W. Howenay</u>
VS A15 (4) 15M 9/55			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filled with Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 1957

BUREAU V. S.

12461

CERTIFICATE OF DEATH

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS Shiloh St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BRYAN Middle OLEN Last BURGESS				4. DATE OF DEATH Month November Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1900	9. AGE (In years last birthday) yrs. 57	IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min 57	IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant (Grocery Store)				10b. KIND OF BUSINESS OR INDUSTRY Grocery Business		11. BIRTHPLACE (State or foreign country) Goff Ka.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Hesikaih Burgess				14. MOTHER'S MAIDEN NAME Laura Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 511-09-7104		17. INFORMANT Mrs. Thomas Faison (Daughter) Address 305 S. Haven Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Aortic Aneurysm; Abdominal Dist. 4.1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 56 , to death , 19 57 , that I last saw the deceased alive on 11-20-57 , and that death occurred at 7A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Md. DATE SIGNED Nov. 21/57							
ACTUAL SIGNATURE Dr. Lee Lawry				M. D. Fruitland, Md.			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry				Fruitland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
22d. LOCATION (City, town, or county) Salisbury, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR NOV 25	
24b. REGISTRAR'S SIGNATURE Mary P. Holloway							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. S.

NOV 5 1927

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12457

Reg. Dist. No. 33

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN Salisbury c. LENGTH OF STAY IN 1b one day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission a. STATE New York b. COUNTY Nassau c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sea Cliff d. STREET ADDRESS 6 Lafayette Place	
3. NAME OF DECEASED (Type or print) Jude First Middle Last J. Chlupsa		4. DATE OF DEATH Month Day Year Nov 17 19 57	
5. SEX M	6. COLOR OF RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1938 19 yrs
9. AGE (In years last birthday) 19		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) New York City, NY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Siegfried Chlupsa		14. MOTHER'S MAIDEN NAME Mary Schmitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO None	
17. INFORMANT Whitting Funeral Home, Glen Head, N.Y.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Crushed Chest Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) Fracture left tibia and femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 26 hrs 26 hrs 26 hrs			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto and Truck Accident	
20c. TIME OF INJURY Month, Day, Year Hour o m. 10:30 PM 11-15-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Street	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 13 Wicomico Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 11-17-57	
EXAMINER'S NAME (Type) Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 23 Nov. 1957	
22c. NAME OF CEMETERY OR CREMATORY Glen Head, New York		22d. LOCATION (City, town, or county) (State) Nov 25 1957	
23. FUNERAL DIRECTOR'S SIGNATURE S. Whitting		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

ROBERT V. E.

RECEIVED
JAN 10 1900

12463

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>8 N. DIVISION ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Chillard</u> Middle <u>Potts</u> Last <u>Cropper</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 7, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. WATERMAN Fishing Commercial</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Cropper</u>		14. MOTHER'S MAIDEN NAME <u>Sabby M. Hastings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. C. P. Cropper - Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute leprosy</u> <u>580X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>57</u> , to <u>11-5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>57</u> , and that death occurred at <u>9:57</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilbur R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>MEDICAL CENTER, SALISBURY, MD.</u>	
PHYSICIAN'S NAME (Type) <u>Wilbur R. Ellis, Jr.</u>		DATE SIGNED <u>MEDICAL CENTER, SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, OR MOVING (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/7/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u>		ADDRESS <u>SALISBURY, MD.</u>	
24a. REC'D BY REGISTRAR <u>11-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Marjorie H. Murray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

NOV 8 1957

RECEIVED

12464

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b XO Mardela			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle DARBY Last DARBY				4. DATE OF DEATH Month Nov. Day 18th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1835		9. AGE (In years last birthday) yrs 71	IF UNDER 1 YEAR Months 11 Days 22	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Laborer)		10b. KIND OF BUSINESS OR INDUSTRY Contractor & Builder		11. BIRTHPLACE (State or foreign country) Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Job Darby				14. MOTHER'S MAIDEN NAME Wille Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mona Darby (Wife) Address Bridge St. Mardela, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 11/14/57 , 19 57 , to 11/18/57 , 19 57 , that I last saw the deceased alive on 11/18/57 , 19 57 , and that death occurred at 11:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 							
ACTUAL SIGNATURE Fred R. Gramse		M.D. Salisbury, Md.					
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		402 S. Division St. Salisbury, Md. Nov. 19/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-	22b. DATE THEREOF Nov. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Mardela Cemstery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR NOV 21 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

2001 11 10

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12465

CERTIFICATE OF DEATH

12460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut. or residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs 9 mo</u>				d. STREET ADDRESS <u>Public School Building, Homalcent Home</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Annie M. Dennis</u>				4. DATE OF DEATH <u>Nov. 24 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25-1874</u>	
9. AGE (In years last birthday) <u>83 1/2</u>		10a. USUAL OCCUPATION (Give kind of work done, leaving out working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsville, MD</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Robert Brittingham</u>			
14. MOTHER'S MAIDEN NAME <u>Amelia White</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>William E. Dennis, Snow Hill, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>degenerative heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs.</u> DUE TO (c)				INTERNAL BETWEEN ONSET AND DEATH <u>7 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8/17/57</u> to <u>11/24/57</u> , that I last saw the deceased alive on <u>11/24/57</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.				DATE SIGNED <u>Salisbury, Md. 11/24/57</u>			
PHYSICIAN'S NAME (Type)				22a. NAME OF CEMETERY OR CREMATORY <u>St. Ann's Methodist</u>			
22b. DATE THEREOF <u>Nov 27/57</u>				22c. LOCATION (City, town, or county) (State) <u>Pittsville MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Dennis</u> ADDRESS <u>Snow Hill, MD</u>				24. REC'D BY REGISTRAR <u>Mary Holloway</u> DATE <u>11/27/57</u>			
24b. REGISTRAR'S SIGNATURE							

RECEIVED

NOV 27 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12466

CERTIFICATE OF DEATH

12466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>OCEAN CITY 105 CAROLYN ST.</u>			
3. NAME OF DECEASED (Type or print) <u>SALLIE LOUISE DILL</u>				4. DATE OF DEATH <u>NOVEMBER 14 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 26, 1864</u>	
9. AGE (in years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>EASTON MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID DUINNING</u>				14. MOTHER'S MAIDEN NAME <u>MARY SATTERFIELD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MRS. NELLIE TORPEY</u> Address <u>OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diverticulitis, with peritonitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>NOVEMBER 11, 1957</u> , to <u>NOVEMBER 14, 1957</u> , that I last saw the deceased alive on <u>NOVEMBER 14, 1957</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond M. Your</u> M.D.				ADDRESS (Street, city or town, state) <u>707 Camden, Salisbury, Md.</u> DATE SIGNED <u>11-14-57</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Embury Berlin Md</u>				24a. REC'D BY REGISTRAR <u>NOV 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 9 1957

RECEIVED

12467 CERTIFICATE OF DEATH

Reg. Dist. No.

332

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 1 mo. 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
f. STREET ADDRESS 916 Duncan Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Julia Middle Donnelly Last Donnelly		4. DATE OF DEATH Month Nov. Day 10 Year 19 57	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1881
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min 57	IF UNDER 24 HRS. Hours 19 Min 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY unk	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Frederick Elinhaus	
14 MOTHER'S MAIDEN NAME Mary Elizabeth Elinhaus		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unk	
16. SOCIAL SECURITY NO unk		17. INFORMANT Hospital Records Address Salisbury, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Metastases 176 X DUE TO Carcinoma of Vagina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6-8 mo. (c)			INTERVAL BETWEEN ONSET AND DEATH 6-8 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 23, 19 57 to Nov. 10, 19 57 that I last saw the deceased alive on Nov. 10, 19 57 , and that death occurred at 5 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED Nov. 10, 19 57			
ACTUAL SIGNATURE G. Kosmahly M.D.		PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF Nov. 13, 19 57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cent.	22d LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		ADDRESS 3000 E. Baltimore St.	24a. REC'D BY REGISTRAR DATE 11/12/57
24b REGISTRAR'S SIGNATURE Mary J. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1957

RECEIVED

12468 CERTIFICATE OF DEATH

12463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>BECK FORD AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lou DONOHOE</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 21 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 20, 1957</u>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>None</u>		13. FATHER'S NAME <u>Brandon Donahoe</u>	
14. MOTHER'S MARRIED NAME <u>Lucille Belle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>C</u>		17. INFORMANT Address <u>Mrs. Brandon Donahoe P.O. Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial fetal atelectasis</u> DUE TO (b) <u>Prematurity (Weight 2 lbs 14 oz)</u> DUE TO (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mother had severe pre-eclampsia & hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 20</u> , 19 <u>57</u> , to <u>Nov 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 21</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. V. Gunderson Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>96 N. Division St. Salisbury MD</u>	
PHYSICIAN'S NAME (Type) <u>R. V. Gunderson Jr.</u>		DATE SIGNED <u>Nov 22 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		ADDRESS <u>Princess Anne MD</u>	
24a. REC'D BY REGISTRAR <u>Nov 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary St. Holway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 29 1957

BUREAU V. E.

12469 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON</u>			
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RETTA MAE DOUGHTY</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 13 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 17 1911</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SILAS WISE</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-20-8501</u>		17. INFORMANT Address <u>LEON DOUGHTY, STOCKTON, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic nephritis</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>NOVEMBER 10 1957</u> to <u>NOVEMBER 13 1957</u> , that I last saw the deceased alive on <u>NOVEMBER 13 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/13/57</u>							
ACTUAL SIGNATURE <u>William R. Ellis Jr.</u> M.D.				DATE SIGNED <u>11/13/57</u>			
PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS SR.</u> <u>SALISBURY MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. HOPE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Watson</u> ADDRESS <u>Pocomoke, MD.</u>				24. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12465

Reg. Dist. No.

12505

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Mardela</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1103 E. Church St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Fullmore</u> Middle <u>E.</u> Last <u>Dryden</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-1905</u>		9. AGE (in years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Filling station operator</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lewis Dryden</u>				14. MOTHER'S MAIDEN NAME <u>Cora King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Margaret Dryden Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>9733</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a.m. <u>11 2</u> p.m. <u>19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Mardela</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 6 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Bellamy</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

RECEIVED

NOV 7 1957

BUREAU V. I.

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 28 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS R.R. 2			
3. NAME OF DECEASED (Type or print) First PAUL Middle Henry Last DAYDEN				4. DATE OF DEATH Month NOVEMBER Day 8 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 29 1877	
9. AGE (In years lost birthday) 80 yrs		IF UNDER 1 YEAR Months 8 Days 8 Hours 0 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Dryden		14. MOTHER'S MAIDEN NAME Elizabeth Warwick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Non -		17. INFORMANT Address Mrs Ruric Ford Princess Anne, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Coronary Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Hypochromic - Severe							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/12 , 19 57 , to 11/8 , 19 57 , that I last saw the deceased alive on 11/8 , 19 57 , and that death occurred at 8:30 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE David Selove M.D.				DATE SIGNED Nov. 8, 1957			
PHYSICIAN'S NAME (Type) Salisbury Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Episcopal		22d. LOCATION (City, town, or county) (State) Princess Anne Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Rimmer ADDRESS Princess Anne				24a. REC'D BY REGISTRAR Nov 11 1957		24b. REGISTRAR'S SIGNATURE Mary W. Williams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1 and 2 should be filed with the registrar.

BUREAU V. S.

NOV 14 1957

RECEIVED

12471 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shoptown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SHIRLEY</u> Middle <u>ANN</u> Last <u>DUNN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>3</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>GEORGE DUNN</u>		14. MOTHER'S MAIDEN NAME <u>ADH RUARK</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT <u>George Dunn</u> Address <u>Shoptown Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>11/18/57</u> DUE TO <u>(Fever, icterus, white count 24,000)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>approx 24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/16</u> 19 <u>57</u> , to <u>11/18</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11/18/57</u> 19 <u>57</u> , and that death occurred at <u>4</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Maryland</u> DATE SIGNED <u>—</u>				
ACTUAL SIGNATURE <u>Alfred C. Keller</u> M.D.		MEDICAL CENTER		
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burton</u>	22d. LOCATION (City, town, or county) (State) <u>Burton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Garmel</u> ADDRESS <u>Shoptown Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>11/19/57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Halloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, it should be detached for use as the burial-transit permit. Then please remove carbon papers. The certificate and 2 should be kept with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

LIBRARY U. S.

RECEIVED

12472

CERTIFICATE OF DEATH

Reg. Dist. No. 882

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>4 hrs.</u>		d. STREET ADDRESS <u>637 S. Division St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Riggin</u> Last <u>Goffrey</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u> <u>JAN. 26</u> <u>1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS STATION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Riggin</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wimbrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Martha Morris</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Plastric Hemorrhage</u> DUE TO <u>Esophageal Varices</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis, Laennec's of liver</u> DUE TO (c) <u>2-3 yrs?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>57</u> , to <u>11/3</u> , 19 <u>57</u> that I last saw the deceased alive on <u>11/3</u> , 19 <u>57</u> , and that death occurred at <u>5:15</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>321 S. Div. St. Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		DATE SIGNED <u>11/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/6/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 7 1957

BUREAU V. S.

1. PLACE OF DEATH o COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Pocomoke</u>	
3. NAME OF (Type or print) <u>John T. Hall</u>		4. DATE OF DEATH <u>November 2 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SAMUEL F. HALL</u>	
14. MOTHER'S MAIDEN NAME <u>MARTHA BRIDDELL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIS C. HALL, POCOMOKE, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>4-0-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-28</u> , 1957, to <u>11-2</u> , 1957, that I last saw the deceased alive on <u>11/2</u> , 1957, and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willis C. Hall</u> M.D.		DATE SIGNED <u>11-2-57</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u>		24a. REC'D BY REGISTRAR <u>VE</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

NOV 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12474

CERTIFICATE OF DEATH

Reg. Dist. No.

12470

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS Williamsburg			
3. NAME OF DECEASED (Type or print) First Marie Middle Sutcliffe Last Harding				4. DATE OF DEATH Month November Day 14 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1908	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Delmar, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman Sutcliffe				14. MOTHER'S MAIDEN NAME Wheatley (Roberta)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Deer's Head Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 19 57 to November 14, 19 57 that I last saw the deceased alive on November 14, 19 57 , and that death occurred at 1:50 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/14/57 ACTUAL SIGNATURE L. V. Madave M. D. PHYSICIAN'S NAME (Type) L. V. Madave, M. D. Deer's Head State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF November 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Washington		22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son				ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR 11-19-57	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloman			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. MARINE

NOV 17 1957

RECEIVED

12475

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaside</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaside Nursing Home, Camden Court</u>				d. STREET ADDRESS <u>Seaside</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Lillie Harrison</u>				4. DATE OF DEATH Month Day Year <u>November 22 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1970</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Killmon</u>				14. MOTHER'S MAIDEN NAME <u>Betty Crockett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>3315 DIV. ST.</u>		17. INFORMANT <u>Mrs. Claude Papp</u> Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>1 month</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. YEARS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury, Md.</u>				20g. (County) <u>Salisbury</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Nov. 1956</u> to <u>Nov 22, 1957</u> , that I last saw the deceased alive on <u>Nov 21, 1957</u> , and that death occurred at <u>6:30 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Pufus S. Gardner, Jr.</u>				ADDRESS (Street, city or town, state) <u>321 S. DIV. ST., Salisbury, Md.</u>			
DATE SIGNED <u>11/22/57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Pufus S. Gardner, Jr.</u>							
22a. BURIAL CREMATION REMOVAL (Specify) <u>11/24/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Onancock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Onancock, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Onancock</u>				ADDRESS <u>Onancock</u>		24a. RECEIVED BY REGISTRAR <u>NOV 26 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>William Onancock</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15ME
BM 2/57

12475

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If inst'l at an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>710 Alvin Ave</u>		d. STREET ADDRESS <u>710 Alvin Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JUANITA</u> <u>ISABELLA</u> <u>HOLLOWAY</u>		4. DATE OF DEATH Month Day Year <u>NOV.</u> <u>3 rd</u> <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1917</u>
9. AGE (in years last birthday) <u>40 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work (Office Clerk)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>W. Austin Moore</u>		14. MOTHER'S MAIDEN NAME <u>Ella M. Adkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. William F. Holloway (Husband)</u>		Address <u>710 Alvin Ave. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia by Hanging</u> <u>974x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Depression</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11 3</u> <u>19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. City or town (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>November 4 1957</u>	
EXAMINER'S NAME (Type) <u>Dr. Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 6, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. RECEIVED BY REGISTRAR <u>NOV 7</u>	24b. REGISTRAR'S SIGNATURE <u>Mary F. Holloway</u>

RECEIVED

NOV 7 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12473

12477

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle VIRGINIA Last INSLEY		4. DATE OF DEATH Month November Day 19th Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1895
9. AGE (In years last birthday) 62 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator (Shirt Factory)	11. BIRTHPLACE (State or foreign country) Athol, Maryland
10b. KIND OF BUSINESS OR INDUSTRY Employee		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Riffin		14. MOTHER'S MAIDEN NAME Roxie Twilley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Charlotte Willey (Daughter)		Address Mardela, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 8 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-19-57 to 11-19-57 , that I last saw the deceased alive on 11-19-57 , and that death occurred at 6:10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. Ellis Jr. M.D.		PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr. Medical Center - Salisbury, Maryland Nov. 19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 23, 1957	22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	22d. LOCATION (City, town, or county) (State) Mardela, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE NOV 21 1957 24b. REGISTRAR'S SIGNATURE Harry Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 21 1947

RECEIVED

12478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Madison Street,		d. STREET ADDRESS 607 Madison Street,	
3. NAME OF DECEASED (Type or print) Ruth Mae Jackson		4. DATE OF DEATH Nov. 2, 1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1891.
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory.	
11. BIRTHPLACE (State or foreign country) Charles Co, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Walter Key Welch		14. MOTHER'S MAIDEN NAME Adeal Higgin.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Eva Harrington (Sister)		Address 607 Madison St. Salisbury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Adenocarcinoma of the 1991 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH. 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 10-6-1957 , and that death occurred at 12:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11-4-57			
ACTUAL SIGNATURE H. A. Briele M.D.			
PHYSICIAN'S NAME (Type) Dr. Henry A. Briele Medical Center, Salisbury, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 5, 57.	22c. NAME OF CEMETERY OR CREMATORY Bivalve Church Cem.	22d. LOCATION (City, town, or county) (State) Bivalve Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.		ADDRESS 4407 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the health certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and completed by the attending physician and completed by the funeral director. Pages 1 and 2 should be filled in by the funeral director, and completed by the attending physician and completed by the funeral director. Pages 1 and 2 should be filled in by the funeral director, and completed by the attending physician and completed by the funeral director.

BUREAU V. S.

NOV 7 1957

RECEIVED

12479

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mattie Middle Lucinda Last Jenkins		4. DATE OF DEATH Month November Day 14 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1893
9. AGE (In years lost birthday) 64 yrs		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 15 Min 57	11. IF UNDER 24 HRS Hours 15 Min 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jenkins		14. MOTHER'S MAIDEN NAME Caroline Banks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Address Deer's Head Hospital Records, Salisbury, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Rheumatic heart disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1957 to Nov. 14, 1957 , that I last saw the deceased alive on Nov. 14, 1957 , and that death occurred at 8 P. M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 11/15/57	
ACTUAL SIGNATURE L. V. Maldve M.D.		PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		ADDRESS ---	
24a. REC'D BY REGISTRAR ---		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1907

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS --			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle Edward Last Legar				4. DATE OF DEATH Month November Day 24 , Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Legar				14. MOTHER'S MAIDEN NAME Mary Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO --		17. INFORMANT Address Deer's Head Hospital, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular accident DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 4 hrs Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paget's disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 26, 1956 to Nov. 24, 1957 , that I last saw the deceased alive on Nov. 24, 1957 , and that death occurred at 9 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/25/57							
ACTUAL SIGNATURE G. Kosmahly M.D.				DEATH BY REGISTRAR DEC 2 1957			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) Havre de Grace Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bell				ADDRESS Havre de Grace			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU V. S.

12481

CERTIFICATE OF DEATH

12471

Reg. Dist. No.

337

1 PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>712 SECOND STREET</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>BERTIE A. LOCKERMAN</u>		4. DATE OF DEATH Month Day Year <u>November 4 1957</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 22, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM C. BONNEVILLE</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA HANCOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>MRS CLEORA B. CHURCHVILLE, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332. DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>from Oct. 25, 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 25, 1957</u> to <u>Nov. 4, 1957</u> , that I last saw the deceased alive on <u>Nov. 3, 1957</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.		DATE SIGNED <u>Nov 4, 1957</u>	
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.		ADDRESS <u>Salisbury, Md</u>	
ATTENDANT'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u> ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 7 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Harry H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 7 1957

BUREAU V. S.

12482

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.A.A. Pen. Gen. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
f. STREET ADDRESS R.D. # 5 (Cedar Heights Lane)		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle LEONARD Last MARSHALL		4. DATE OF DEATH Month NOVEMBER Day 29th Year 19 57	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14th, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private Club (Steward)		10b. KIND OF BUSINESS OR INDUSTRY Hamilton New York	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Marshall		14. MOTHER'S MAIDEN NAME Annie Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Amy M. Marshall (Wife)		Address R.D. # 5 Cedar Heights Lane - Quantico Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1945 , 19____, to death , 19____, that I last saw the deceased alive on 11-29-57 , 19____, and that death occurred at 1:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Md DATE SIGNED Nov. 30 1957			
ACTUAL SIGNATURE Lee L Lawry M.D.		PHYSICIAN'S NAME (Type) Dr. Lee Lawry Fruitland, Maryland Nov. 30 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1st, 1957	22c. NAME OF CEMETERY OR CREMATORY Meth. Church Cemetery	22d. LOCATION (City, town, or county) (State) Bivalve, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. ADDRESS		24a. REC'D BY REGISTRAR DEC 2 1957	24b. REGISTRAR'S SIGNATURE Mary H Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 2 1950
BUREAU V. S.

12483

CERTIFICATE OF DEATH

1247932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>312 Barclay Street</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>T.</u> Last <u>MASON</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George T. Clayton</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Mason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lillian T. Brown, Salisbury, Maryland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u> <u>5 yr -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Nov 19</u> 19 <u>57</u> , to <u>Nov 19</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 19</u> 19 <u>57</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.		DATE SIGNED <u>Nov 20, 1957</u>	
PHYSICIAN'S NAME (Type) <u>EARL M. BEARDSLEY</u>		<u>SALISBURY, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>11-21-57</u>	22c. NAME OF CEMETERY OR CREMATION <u>John H. Taylor Mem.</u>	22d. LOCATION (City, town, or county) (State) <u>Tempsville, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>Poco 16, Va.</u>		24a. REC'D BY REGISTRAR <u>NOV 25 1957</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5

3 should be detached prior to burial, cremation, or removal, and in any event within 72 hours after death.

FRANKLY V. S.

10. 10.

RECEIVED

12484

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>811 Baltimore Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>John</u> Last <u>Massey</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR: Months <u>7</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL J. MASSEY</u>				14. MOTHER'S MAIDEN NAME <u>HESTER MORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS. R.S. MASSEY</u> Address <u>OCEAN CITY, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis & Uremia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> 19 <u>57</u> to <u>Nov 10</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 10</u> 19 <u>57</u> , and that death occurred at <u>8:57 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Gilmore</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>David Gilmore</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>Nov 1 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Halloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 14 1957
BUREAU Y. S.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
and in any event within 72 hours after death.

VS. A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812481											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 3, 5, 6, 8 Film 222 11-21-57 et, From Birth Cert. No. 325											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Athol				c. LENGTH OF STAY in 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Athol					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Athol						d. STREET ADDRESS Athol					
3. NAME OF DECEASED (Type or print) First Oxalene Middle Deliese Last McCoy						4. DATE OF DEATH Month 11- Day 15- Year 19 57					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 7, 1957		9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Month 2 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Athol, Md.			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME SIDNEY MCCOY						14. MOTHER'S MAIDEN NAME BETTIE G. MCCOY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT BETTIE G. MCCOY Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia: aspiration of vomitus. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden.											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Athol (County) Wicomico (State) Md		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11-19-57			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11/18/57		22c. NAME OF CEMETERY OR CREMATORY MT Zion		22d. LOCATION (City, town, or county) SHARPTOWN (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart				ADDRESS WEST ROAD Schickly		24a. REC'D BY REGISTRAR DATE V 21 1957		24b. REGISTRAR'S SIGNATURE Harold C. Owens			

RECEIVED

NOV 21 1957

RECEIVED

12486

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d STREET ADDRESS 1200 N. Division St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First PRESTON Middle ROYCE Last MEARS JR.				4. DATE OF DEATH Month NOVEMBER Day 9th Year 19 57			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 4, 1957		9 AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 0 Days 8 Hours 5 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Md. (Hospital)		12. CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Preston Royce Mears				14 MOTHER'S MAIDEN NAME Margaret Ann Pusey			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17 INFORMANT Address Mr. Preston Royce Mears (Father) 1200 N. Div. St. Salisbury, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia							
763.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) awaiting autopsy report							
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
				20f (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov 4, 1957 to Nov 9, 1957 , that I last saw the deceased alive on Nov 9, 1957 , and that death occurred at 4:4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Alberta Mattax M.D. 711 Camden Ave				DATE SIGNED 11/12/57			
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax				711 Camden Ave. Salisbury, Md. Nov. 1 57			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF Nov. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a REC'D BY REGISTRAR AND REGISTRAR'S SIGNATURE NOV 13 1957 Mary Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

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RECEIVED
NOV 13 1957
BUREAU V. S.

12487

CERTIFICATE OF DEATH

12483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. at Medical Center		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First CYNTHIA Middle ESTELLE Last MESSICK		4. DATE OF DEATH Month NOVEMBER Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1957
9. AGE (In years lost birthday) 0 yrs.		10. IF UNDER 1 YEAR 2 Months 4 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Md. (Hospital)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Arthur Amos Messick		14. MOTHER'S MAIDEN NAME Patricia Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr Arthur A. Messick (Father) Address W.F. Allen Co. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 4 x x x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from birth , 19 11/12 , 19 57 , that I last saw the deceased alive on 11/12 , 19 57 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William B. Smith M.D.		ADDRESS (Street, city or town, state) DR. WILLIAM B. SMITH The Medical Center Rt. 2, Salisbury, Md. DATE SIGNED Nov. 14, 1957	
PHYSICIAN'S NAME (Type) Dr. William B. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. ADDRESS		24a. REC'D BY REGISTRAR NOV 14 1957	24b. REGISTRAR'S SIGNATURE Mary Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, or the registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
NOV 14 1967
BUREAU V. S.

12488

CERTIFICATE OF DEATH

12488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle — Last Moore				4. DATE OF DEATH Month November Day 19th Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unk.	
9. AGE (In years last birthday) About 80rs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Will Craig				14. MOTHER'S MAIDEN NAME Martha Craig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — INTERVAL BETWEEN ONSET AND DEATH 4 days Years —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple osteoarthritis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 22, 19 55 to Nov. 19, 19 57 , that I last saw the deceased alive on Nov. 19, 19 57 , and that death occurred at 12:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/19/57							
ACTUAL SIGNATURE G. Kosmahly M. D. Salisbury, Maryland 11/19/57							
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D. Deer's Head State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-25-57		22c. NAME OF CEMETERY OR CREMATORY Deer's Head State Hospital		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE —				ADDRESS —		24a. REC'D BY REGISTRAR DATE 11/26/57	
						24b. REGISTRAR'S SIGNATURE Mary Holloway	

NOV 27 1957

BUREAU V.

RECEIVED

12489 CERTIFICATE OF DEATH

12485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS Appleby Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Robinson Last Moore		4. DATE OF DEATH Month November Day 25 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1866
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 91 Days 91 Hours 91 Min. 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Robinson		14. MOTHER'S MAIDEN NAME Elizabeth Watters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sq. cell Ca. of face			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 16, 1955 to Nov. 25, 1957 , that I last saw the deceased alive on Nov. 25, 1957 , and that death occurred at 9:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Maldie		DATE SIGNED 11/26/57	
PHYSICIAN'S NAME (Type) I. Maldie, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-28-57	22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR 11/29/57		24b. REGISTRAR'S SIGNATURE John M. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,

3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 4 1911

BUREAU V. S.

12480 CERTIFICATE OF DEATH

Reg. Dist. No.

12486332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Clarence</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1877</u>		9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Morris</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Maher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>unk</u>		16. SOCIAL SECURITY NO <u>unk</u>		17. INFORMANT <u>Mr. William C. Morris (Son)</u> <u>Cleveland, Ohio</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, secondary, hypostatic</u> <u>441X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Arteriosclerosis, general</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 31, 1957</u> , to <u>Nov. 10, 1957</u> , that I last saw the deceased alive on <u>Nov. 10, 1957</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>Nov. 10, 1957</u>							
ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D.				PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Nov. 12-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>J. Wm Lee & Sons Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOWARD & COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1957

RECEIVED

12491 CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Fenwix Road</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE McCABE</u> First Middle Last		4. DATE OF DEATH <u>November 2, 1957</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>
13. FATHER'S NAME <u>Elijah McCabe</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Murray</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>222-24-6101</u>		17. INFORMANT <u>Lee Murray</u> Address <u>Selbyville, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>11-20</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>11-2</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Men</u>	22d. LOCATION (City, town, or county) (State) <u>Selbyville, Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter A. Kelly</u>		24a. REC'D BY REGISTRAR <u>11/7 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Murray</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. E.

NOV 7 1957

RECEIVED

12492 CERTIFICATE OF DEATH

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEL MAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PELIN-SULA GEN. HOSPITAL</u>				d. STREET ADDRESS <u>308 ELIZABETH ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELVIN LEE O'NEAL</u>				4. DATE OF DEATH Month Day Year <u>Nov. 14 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-1925</u>	
9. AGE (in years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APPLIANCE</u>		11. BIRTHPLACE (State or foreign country) <u>DELMAR-DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL O'NEAL</u>				14. MOTHER'S MAIDEN NAME <u>EDITH M. HASTINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-07-9217</u>		17. INFORMANT Address <u>Daniel F. O'Neal, Delmar Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelogenous Leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 14</u> , 19 <u>57</u> , to <u>Nov. 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 14</u> , 19 <u>57</u> , and that death occurred at <u>10 A. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel F. O'Neal</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>Nov. 14, 1957</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Not alive</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>Nov 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If page 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 18 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12506

CERTIFICATE OF DEATH

Reg. Dist. No. 12489337

1. PLACE OF DEATH a. COUNTY Wilcomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wilcomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards (rural)				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *****				d. STREET ADDRESS RFD			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) STELLA First C. Middle PHILLIPS Last				4. DATE OF DEATH Month Nov. Day 7 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1879	
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas W. Baker				14. MOTHER'S MAIDEN NAME Mary Elizabeth Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ***		16. SOCIAL SECURITY NO. (If yes, give year or date of service) *****		17. INFORMANT Address Mr. Oliver Phillips Willards, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral sclerosis DUE TO (c) Chr. Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1957 , to Nov 7, 1957 , that I last saw the deceased alive on Nov 7, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Chas. R. Law M.D.				Berlin Md Nov 8-1957			
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/56		22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Willards, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Lillyville Del.				24a. REC'D BY REGISTRAR NOV 12 1957		24b. REGISTRAR'S SIGNATURE Mary H. Hollways	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

RECEIVED
NOV 12 1957
BUREAU V. S.

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NOV 21 1937

VS A15 (4)
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U. S. AIR FORCE

NOV 1 1957

RECEIVED

12508 CERTIFICATE OF DEATH

12491322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradley St				d. STREET ADDRESS Bradley St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First XX LAURA		Middle TILDEN		Last PHIPPIN		4. DATE OF DEATH Month NOV.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1876	
9. AGE (In years last birthday) 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		11. BIRTHPLACE (State or foreign country) Quantico Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James B. Phippin				14. MOTHER'S MAIDEN NAME Ianthia Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Thomas E. Shores (Daughter) Bradley St Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 400... DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct. 30th, 1957, to Nov. 9th, 1957, that I last saw the deceased alive on Nov. 9th, 1957, and that death occurred at 6:10 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. William Emrich				DATE SIGNED Hebron, Md. Nov. 11, 1957			
PHYSICIAN'S NAME (Type) Dr. William Emrich				Hebron, Maryland Nov. 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE NOV 13 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. DUNN

NOV 13 1957

RECEIVED
FBI

12493

CERTIFICATE OF DEATH

Reg. Dist. No. 700

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 2 yrs. 10 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Pilkerton				4. DATE OF DEATH Month November Day 9th Year 19 57			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thomas				14. MOTHER'S MAIDEN NAME Mary Tippet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. ---		17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Years						INTERVAL BETWEEN ONSET AND DEATH 9 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 11, 1955 to Nov. 9, 1957 , that I last saw the deceased alive on Nov. 9, 1957 , and that death occurred at 3:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/9/57							
ACTUAL SIGNATURE G. Kosmahly M.D.				PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-11-57		22c. NAME OF CEMETERY OR CREMATORY St Marys	
22d. LOCATION (City, town, or county) (State) Newport Md				22e. FUNERAL DIRECTOR'S SIGNATURE Archard Mc Saplata md			
22f. ADDRESS Deer's Head State Hospital				24a. REC'D BY REGISTRAR 11/12/57		24b. REGISTRAR'S SIGNATURE Julia H. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 14 1957

BUREAU V. S.

12494

CERTIFICATE OF DEATH

12493

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1006 S. Division St		d. STREET ADDRESS 1006 S. Division St	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle EMILY Last POPE		4. DATE OF DEATH Month NOVEMBER Day 17 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 4 Days 20 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Asbury Kelley		14. MOTHER'S MAIDEN NAME Mary Esham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 	
17. INFORMANT Mr. William P. Pope (Husband)		Address 1006 S. Division St. Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 mon
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 50 , to death , 19 , that I last saw the deceased alive on 11-16-57 , 19 , and that death occurred at 10:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lee L Lawry		ADDRESS (Street, city or town, state) Fruitland, Md.	
DATE SIGNED Nov. 18/57			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry		Fruitland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS 	
24a. REC'D BY REGISTRAR NOV 25 1957		24b. REGISTRAR'S SIGNATURE Mary H Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, registrar, or other person in charge of the funeral should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2507 - 100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12495

CERTIFICATE OF DEATH

Reg. Dist. No.

1249537

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>		d. STREET ADDRESS <u>204 CAROLINE ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE THOMAS POWELL</u>		4. DATE OF DEATH Month Day Year <u>NOV. 4, 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9, 1863</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD TRUITT</u>		14. MOTHER'S MAIDEN NAME <u>MARY TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. ANNIE OUTTEN</u>		Address <u>OCEAN CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>NO</u> DUE TO (c) <u>NO</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>57</u> to <u>11/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/4</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul J. Gilmore</u>		DATE SIGNED <u>Nov 4, 1957</u>	
NAME (Type) <u>Paul J. Gilmore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna B. Burke</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>PROV</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 7 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1249532

12509

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico Rt. #1				c. LENGTH OF STAY IN 1b 5 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Route # 1			
3. NAME OF DECEASED (Type or print) First Theresa Middle Karen Last Price				4. DATE OF DEATH Month 11 Day 4 Year 19 57			
5. SEX F M		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/28/1957	
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min 5		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Levin Turner				14. MOTHER'S MAIDEN NAME Helen Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give war or dates of service) No		17. INFORMANT Address Miss Helen Price, Quantico, Md Rt #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Influenza Virus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 days (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-28, 1957 to 11-4, 1957 that I last saw the deceased alive on 11-3, 1957 and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL PHYSICIAN Arthur D. Browne M.D. PHYSICIAN'S NAME (Type) Arthur D. Browne, M.D. 600 West Isabella Street, Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Quantico, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE Nov 3 1957		24b. REGISTRAR'S SIGNATURE May H. Hollings	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV

1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12496

CERTIFICATE OF DEATH

12496

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>				d. STREET ADDRESS <u>17 Chestnut Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Slacum</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4, 1879</u>		9. AGE (in years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Seni Slacum</u>				14. MOTHER'S MAIDEN NAME <u>Norothy Huffard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>76-03-1600</u>		17. INFORMANT <u>Adah Slacum - Delmar Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Benign Prostatic Hypertrophy</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTES</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Oct 28</u> , 19 <u>57</u> , to <u>Nov 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>57</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B Long</u> M.D.				ADDRESS (Street, city or town, state) <u>Med Center Salisbury Md</u> DATE SIGNED <u>11/10/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>First Methodist</u>		22d. LOCATION (City, town, or county) <u>Salisbury Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Mansel Co - Salisbury Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR _____ DATE _____		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 13 1957

BUREAU V. E.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12497

CERTIFICATE OF DEATH

12497

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pen. Gen. Hospital</u>		d. STREET ADDRESS <u>Main St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LIZZIE</u> Middle <u>ELLEN</u> Last <u>SOLLOWAY</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>19th</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1877</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>R.D. # Mardela Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John P. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bradley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Mary T. Brown (Sister)</u> Address <u>Mardela, Maryland</u>		Box # <u>27</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Uremia</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Metastases</u> DUE TO (c) <u>Carcinoma of Gall Bladder</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-13-</u> 19 <u>57</u> , to <u>11-19-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11-19-</u> 19 <u>57</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H. Cayaves</u> M.D.		ADDRESS (Street, city or town, state) <u>222 N. Division St., Salisbury Md.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES, M.D.</u>		DATE SIGNED <u>11/19/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 23, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mardela Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. If 1 and 2 should be filed with it prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. ARMY

NOV 11 1947

RECEIVED

12498 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Item 7 11-23-57 et
12498-1
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 yr 10½ mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First John Middle -- Last Spencer				4. DATE OF DEATH Month Nov. Day 18th Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY GANNING FACTORY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 213-22-7775		17. INFORMANT Address Deer's Head State Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis						1½ days	
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) Arteriosclerosis, general						Years	
DUE TO							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Jan. 3, 1955 to Nov. 18, 1957 , that I last saw the deceased alive on Nov. 18, 1957 , and that death occurred at 5:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 11/19/57	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Deer's Head State Hospital			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11.23/57	22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY	22d. LOCATION (City, town, or county) (State) PRINCESS ANNE				
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr.				24a. REC'D BY REGISTRAR DATE 12/2/57	24b. REGISTRAR'S SIGNATURE Mary H. Holloway		

RECEIVED

DEC 3 1957

BUREAU V. S.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. STREET ADDRESS 401 Race St		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First THOMAS Middle PETER Last STEELE		4. DATE OF DEATH Month NOVEMBER Day 3rd Year 19 57					
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Laborer of Gen. Outdoors Adv.Co.)				10b. KIND OF BUSINESS OR INDUSTRY Delaware		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME Isaac Steele				14. MOTHER'S MAIDEN NAME Unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 223-10-2299		17. INFORMANT Mr. Thomas P. Steele Jr. 401 Race St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis 502x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10 , 19 50 , to 11/3 , 19 57 , that I last saw the deceased alive on 11/3/50 , 19 50 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St Salisbury, Md DATE SIGNED Nov. 4 1957							
RETURN SIGNATURE F. R. Gramse M.D.							
PHYSICIAN'S NAME (Type) Dr. Fred Gramse				S. Division St Salisbury, Md Nov. 4 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. RECEIVED BY REGISTRAR DATE NOV 15 1957			
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be delivered for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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12510 CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Route # 2 Springhill Road.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Route # 2 Springhill Road. e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank First George Middle Thomas Last		4. DATE OF DEATH Nov. Month 1. Day 1957. 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 24. 1873.
9. AGE (In years and birthday) yrs 84		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prof. Dynamiter		10b. KIND OF BUSINESS OR INDUSTRY Blasting.	11. BIRTHPLACE (State or foreign country) Burns, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James B. Thomas	
14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Burt Thomas (Son) Hebron, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 to 11-1 , that I last saw the deceased alive on 10-31 , 1957 , and that death occurred at 7.05A M, from the causes and on the date stated above. ADDRESS (street, city or town, state) Salisbury Md DATE SIGNED 11-1-57			
ACTUAL SIGNATURE Phillip A. Insley M.D.		PHYSICIAN'S NAME (Type) Dr. Phillip A. Insley 116 E. Main St. Salisbury, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Nov. 4. 57.	Hebron Cem.	Hebron, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company Salisbury, Maryland.		24a. REC'D BY REGISTRAR DATE 11-1-57 24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
F 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
F 4 should be detached for use as the burial-transit permit. Then please remove carbon papers.
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F 100 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12500

CERTIFICATE OF DEATH

12501 332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>205 W. COLLEGE AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GEN. HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patricia</u> First <u>Doody</u> Middle <u>Truitt</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 22, 1914</u> yrs. <u>43</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>PATRICK HENRY DOODY</u>				14. MOTHER'S MAIDEN NAME <u>ELDISE MYBRIETY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service) <u> </u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>KING TRUITT - SAME</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure & Pneumonia</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhages from Enlarged Venous</u> DUE TO <u> </u> (c) <u>Cirrhosis of Liver</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>10-1</u> , 1957, to <u>11-2</u> , 1957, that I last saw the deceased alive on <u>11-2</u> , 1957, and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>DR. WILLIAM B. SMITH The Medical Center 2, Salisbury, Md.</u>			
DATE SIGNED <u>11/4/57</u>							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/5/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) <u>SALISBURY, MD</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Johnson</u>				ADDRESS <u>SALISBURY, MD</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>11-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>							

RECEIVED

NOV 7 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS R.D. # 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH Middle ELIZABETH Last TRUITT		4. DATE OF DEATH Month NOVEMBER Day 13 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Parsonsburg, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Rufus Evans		14. MOTHER'S MAIDEN NAME Rachel Briddell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Kendall J. Truitt (Son) Address S. Main St. Berlin, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension and degenerative DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Heart Disease DUE TO (c) Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Centurion
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-13 , 19 57 , to 19 , that I last saw the deceased alive on 11-13 , 19 57 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED Nov 13 1957			
ACTUAL SIGNATURE William R. Ellis Jr. M.D.			
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr. Medical Center- Salisbury, Maryland Nov. 13, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsonsburg Cemetery	22d. LOCATION (City, town, or county) (State) Parsonsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. ADDRESS Salisbury, Maryland			
24a. REC'D BY REGISTRAR Nov 15 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1250337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stilesbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stilesbury</u>	
c. LENGTH OF STAY IN 1b <u>4 weeks</u>		d. STREET ADDRESS <u>113 W. Park Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 W. Park Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>L.</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30-1869</u>
9. AGE (In years last birthday) <u>87 1/2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>17m Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pocomoke, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Martha Sheppard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, army/navy) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Walter Sayler, Stilesbury, Md</u>		18. ADDRESS <u>Stilesbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22/57</u> 19____ to <u>11/28</u> 19____ that I last saw the deceased alive on <u>11/22</u> 19____, and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. C. Mitchell</u>		M.D. <u>11/28/57</u> ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas E. Sumner</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

BUREAU V. S.

1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12503

CERTIFICATE OF DEATH

12504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 29X0.2			
3. NAME OF DECEASED (Type or print) BABY				4. DATE OF DEATH November 3-1957			
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1957	
9. AGE (In years last birthday) 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N		11. BIRTHPLACE (State or foreign country) SALISBURY MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROLAND WHITTINGTON				14. MOTHER'S MAIDEN NAME ELIZABETH TAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT MR. ROLAND WHITTINGTON Address BERLIN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Cerebral Palsy DUE TO Prematurity (1050 grams) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 15 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2 1957, to Nov 3 1957, that I last saw the deceased alive on Nov 3 1957, and that death occurred at 9:30 AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/3/57							
ACTUAL SIGNATURE Alfred C. Kello M.D.				PHYSICIAN'S NAME (Type) Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/57		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) Berlin Md	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md				24a. REC'D BY REGISTRAR NOV 8 1957		24b. REGISTRAR'S SIGNATURE Mary H. Hallway	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15200

Dec 1957
Bridgette

11/11/57
Bridgette

11/11/57 - 11/11/57

11/11/57 - 11/11/57

11/11/57

BUREAU V. 2

NOV 6 1957

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12504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 720 Greenwood Road			
3. NAME OF DECEASED (Type or print) First Marie Middle S. Last Zimmerman				4. DATE OF DEATH Month Nov. Day 25 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 25 Days 19 Hours 57		IF UNDER 24 HRS. Months 12 Days 12 Hours 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Bartling				14. MOTHER'S MAIDEN NAME Johanna Kreusler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca. of bladder DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1957 , to Nov. 25, 1957 , that I last saw the deceased alive on Nov. 25, 1957 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 11/26/57							
ACTUAL SIGNATURE L. V. Maldve		M.D. Deer's Head State Hospital 11/26/57					
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29/57		22c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.				ADDRESS 4101 Edmondson Ave.			
24a. REC'D BY REGISTRAR NOV 27 1957				24b. REGISTRAR'S SIGNATURE Mary Hallway			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 3

NOV 27 1957

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